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In The

Supreme Court of the United States

October Term, 1994

AMERICAN REPUBLIC INSURANCE COMPANY,

Petitioner,

v.

SUPERINTENDENT OF INSURANCE
OF THE STATE OF MAINE,

Respondent.

Petition For Writ Of Certiorari To The Supreme Judicial Court Of The State Of Maine

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Contract Clause of the United States Constitution protects health insurance providers from state legislation that retroactively modifies insurance policies to include coverage for preexisting medical conditions the provider and its insured specifically and expressly excluded from coverage.

2. Whether that portion of a legislative Act making the Act retroactive, and thereby causing it to substantially impair private contracts, can be upheld under the Contract Clause on the ground that a broad public purpose is served when the Act's retroactive effect is narrowly focused on several hundred insurance policies issued by a single insurance company.

3. Whether the Contract Clause requirement that a significant and legitimate public purpose be served by a statute that substantially impairs private contracts is met when the legislative Act of which the statute is a part serves such a purpose, but the impairing statute itself, which makes the Act retroactive, does not.

4. Whether it is appropriate under the Contract Clause to grant absolute deference to legislative judgment when a challenge is made to the necessity and reasonableness of retroactive legislation that substantially impairs private contracts.

PARTIES TO PROCEEDINGS

Petitioner is American Republic Insurance Co.

Respondent is the Superintendent of Insurance for the State of Maine.

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AMERICAN REPUBLIC INSURANCE COMPANY,

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Petition For Writ Of Certiorari To The Supreme Judicial Court Of The State Of Maine

PETITION FOR WRIT OF CERTIORARI

Petitioner, American Republic Insurance Company, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Supreme Judicial Court of the State of Maine entered on September 21, 1994.

OPINIONS BELOW

The unreported opinion of the Supreme Judicial Court of the State of Maine is included in the Appendix as Exhibit A.

The Kennebec County Superior Court opinion and order reversed by the Maine supreme court is included in the Appendix as Exhibit B.

The Superintendent of Insurance decision overturned by the Maine superior court is included in the Appendix as Exhibit C.

JURISDICTION

Jurisdiction in this case is premised upon 28 U.S.C. § 1257(a) for review by certiorari of the judgment and opinion of the Supreme Judicial Court of Maine. A written opinion was issued by that court on September 21, 1994.

Jurisdiction in the Kennebec County Superior Court was based on Me. Rev. Stat. Ann., tit. 4, § 105. The case arises under Me. Rev. Stat. Ann., tit. 24-A, § 236 and Me. Rev. Stat. Ann., tit. 5, § 11001. Jurisdiction in the Supreme Judicial Court of Maine was based on Me. Rev. Stat. Ann., tit. 4, § 57.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional provision involved is the Contract Clause of the United States Constitution: "No state shall . . . pass any . . . Laws impairing the Obligation of Contracts . . . . " U.S. Const. art. 1, § 10, cl. 1.

The Maine Constitution contains a clause that is virtually identical: "[t]he Legislature shall pass no . . . law

impairing the obligation of contracts . . . . " Me. Const. art. 1, § 11. In interpreting this aspect of the Maine Constitution, the courts of that state have followed the United States Supreme Court's analysis of the federal Contract Clause.

The state legislation at issue, the Continuity of Health Insurance Coverage Act, Me. Rev. Stat. Ann., tit. 24-A, §§ 2848-2850 (1990), is included in the Appendix as Exhibit E. The pertinent provisions are set forth below:

> **§ 2850. Limitations on exclusion and waiting periods**
>
> . . . .
>
> 2. **Limitation**. An individual policy issued by an insurer may not impose a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment.
>
> **Me. Pub. L. 1989, ch. 867:**
>
> **Sec. 10. Application**. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 1990. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

STATEMENT OF THE CASE

American Republic is an Iowa mutual insurance company that, until 1991, was the only provider in Maine of individual policies of medical insurance guaranteed to be renewable for the life of the insured. These policies provide that benefits may not be changed without the consent of the insured, and the premium may be changed only in accordance with a uniform schedule based on the insured's age or if the change applies to the entire class of policyholders to which the insured belongs. Before such a policy was issued, the insured was asked to list any preexisting medical conditions. These could be excluded from coverage. Of the 3,227 policies in effect in Maine on December 1, 1990, 560 contained riders excluding coverage for one or more defined conditions.

In 1990, the Maine legislature passed the Continuity of Health Insurance Coverage Act, Me. Rev. Stat. Ann., tit. 24-A, §§ 2848-2850. The focus of the Act was to provide continuity of health benefits coverage for persons who change group insurance plans, or whose group plan changes insurers. However, the Act included a provision directed toward persons who are insured through individual policies. This provision prohibited individual health insurers from excluding preexisting conditions from coverage for the life of the policy. Section 2850(2) provided in its entirety:

> **2. Limitation.** An individual policy issued by an insurer may not impose a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that as of the effective date of the coverage

requires ongoing medical observation or treatment.

Me. Rev. Stat. Ann., tit. 24-A, § 2850(2).

This prohibition was limited to companies that offered individual medical policies. No such limitation against permanent exclusion of preexisting conditions was placed on group insurers.

Pursuant to the applicability clause, section 2850(2) was to apply to "all policies and contracts executed, delivered, issued for delivery, or *renewed* in the State on or after December 1, 1990." Me. Pub. L. 1989, ch. 867, § 10 (emphasis added). The applicability clause further provided that all contracts were "deemed to be renewed no later than the next yearly anniversary of the contract date." App. 48.

Among the health insurers to whom the Act was directed, American Republic is uniquely and severely affected. Because American Republic is contractually obligated to renew its policies, the Act retroactively forces it to rewrite its policies to cover medical conditions both it and its insureds had specifically agreed would not be covered. Moreover, there is no realistic possibility American Republic will be able to recoup the substantial cost of the extra coverage the State has mandated it provide. Under Maine law, American Republic must obtain approval from the Bureau of Insurance before increasing its premiums. The bureau has declined to approve American Republic's request.

As a practical matter, American Republic could not raise its premiums enough to cover the added costs even if the State allowed an increase. Actuarial studies show

that American Republic could not break even unless it successfully imposed either a 144% premium increase on all Maine policies with preexisting condition exclusions or a 25% premium increase on all policies issued in Maine. Either attempt would drive away countless insureds, thereby requiring even higher premiums for any who remained with American Republic.

For nearly a year after section 2850(2) was enacted, it was thought to be applicable only prospectively. Even the Bureau of Insurance, which crafted much of the language of the Act, assumed it was to apply only to policies *issued* after its effective date. Indeed, once the bureau realized the retroactive effect of the statutory language, it proposed corrective legislation. This effort failed. American Republic then requested that the bureau exempt its guaranteed renewable policies from the retroactive application of section 2850(2).

While American Republic's request was pending before the Bureau of Insurance, an American Republic insured named Herbert Wentworth filed a complaint with the bureau. Wentworth had purchased a guaranteed renewable policy in 1988. The policy specifically excluded coverage for cataracts, a condition that had previously been diagnosed by Wentworth's optometrist. After section 2850(2) was enacted, Wentworth paid the premium to continue his policy, then sought to require American Republic to remove the exclusion for cataracts.

On July 23, 1992, the Superintendent of Insurance issued a Decision and Order rejecting American Republic's Contract Clause objection to section 2850(2) as

applied retroactively to guaranteed renewable policies.[1] The order directed American Republic to "remove the preexisting condition exclusion for cataracts from Mr. Wentworth's policy retroactively effective to June 7, 1991, and make payment on any claims Mr. Wentworth has incurred since that time as a result of treatment for the excluded condition." App. 25. It did not address any policy other than Wentworth's.

American Republic appealed the superintendent's decision to the Kennebec County Superior Court.[2] During the pendency of the appeal, Wentworth submitted, and American Republic paid, $9,709.22 for medical expenses attributable to cataracts.

In an Opinion and Order dated July 28, 1993, as amended by Order dated September 19, 1993, the superior court vacated the superintendent's decision and declared section 2850(2) unconstitutional as applied to the guaranteed renewable policies issued by American Republic prior to the effective date of section 2850(2).[3] The superior court ruled that such retroactive application constitutes an impairment of contract under the Maine and the United States Constitutions. App. 13.

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[1] Decision and Order, Ex. C, App. 15-26. The Superintendent's specific finding that "§ 2850 does not amount to an unconstitutional impairment of contract" is found at p. 22 of the Appendix.

[2] Complaint for Review of Final Agency Action. Ex. D., App. 27-32. The allegation of a violation of the Contract Clause is found at p. 30 of the Appendix.

[3] Opinion and Order, Ex. B, App. 9-14.

The superior court's decision was reversed by the Maine Supreme Judicial Court.[4] In an Opinion dated September 21, 1994, the court held:

> Although American Republic may have suffered a substantial impairment of its contracts, section 2850(2) has a significant and legitimate public purpose, and the adjustment of the parties' rights and responsibilities are reasonable and of a character appropriate to that purpose. Accordingly, we find no constitutional infirmity and vacate the judgment.

App. 1-2.

The Maine court's cursory opinion misapplies the three-stage Contract Clause analysis set forth in *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400 (1983). There, the Court described the process as follows:

> The threshold inquiry is "whether the state law has, in fact, operated as a substantial impairment of a contractual relationship." . . .
>
> If the state regulation constitutes a substantial impairment, the State, in justification, must have a significant and legitimate public purpose behind the regulation, such as the remedying of a broad and general social or economic problem. . . .
>
> Once a legitimate public purpose has been identified, the next inquiry is whether the adjustment of "the rights and responsibilities of contracting parties [is based] upon reasonable conditions and [is] of a character appropriate to

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[4] Opinion, Ex. A, App. 1-8.

> the public purpose justifying [the legislation's] adoption."

Id., at 411-12 (alterations in original) (citations omitted).

The Maine court began by assuming the obvious, that the retroactive application of section 2850(2) substantially impairs American Republic's guaranteed renewable policies. Regrettably, the court went no further with its first-stage analysis. No attempt was made to gauge the severity of the substantial impairment.

For the second and third stages of its *Energy Reserves* analysis, the Maine court failed to focus on the retroactive application of the statute. Instead, the court looked to the assumed purpose and appropriateness of the statute as a whole to uphold the constitutionality of its retroactive application. Moreover, the court gave what amounted to absolute deference to the legislature despite the absence of any evidence in the record as to the purpose of or need for the retroactive application of section 2850(2). In taking this overly deferential approach, the Maine court effectively reverts Contract Clause analysis to the sort of meaningless rubber stamp approval process that was thought to exist before this Court's decisions in *United States Trust Co. v. New Jersey*, 431 U.S. 1 (1977), and its progeny.

REASONS FOR GRANTING THE WRIT

In the chaotic rush to control the cost of health care, legislation is being considered in virtually every state that would dramatically change the way medical insurance policies are written. Small insurance companies, lacking the political clout to protect themselves, are particularly at risk of being unfairly affected by sweeping government initiatives. They must look to the courts for protection through the fair, firm, and reasoned application of basic constitutional safeguards.

In this setting, the instant case presents an exceptional opportunity for the Court to correct a particular injustice, to provide needed clarification of the constitutional boundaries within which governments must operate as they attempt to mandate health insurance reform, and to halt the growing erosion by lower courts of the analytical framework carefully laid by this Court's prior Contract Clause opinions.

Beginning with *United States Trust Co. v. New Jersey*, 431 U.S. 1 (1977), the Contract Clause has enjoyed renewed vigor as a source of protection against state interference with the orderly relations of private parties. In *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234 (1978), the Court used strong language to emphasize that severe impairments of private contractual obligations require "a careful examination of the nature and purpose of the state legislation." *Id.* at 245.

Subsequent decisions by the Court, however, have arguably evinced a more deferential attitude toward legislative judgment, prompting one noted scholar to suggest that the opinion in *Allied Structural Steel* has been

effectively overruled.[5] The possible shift in the Court's position, combined with the fact that none of the Court's Contract Clause cases have involved insurance contracts, has contributed to a division among the lower courts on the specific issue of whether an impermissible impairment occurs when an insurer is forced to undertake an obligation beyond that to which it had agreed by contract. *Cf. Calfarm Ins. Co. v. Deukmejian*, 771 P.2d 1247 (Cal. 1989) (en banc) (limitation on insurer's power to refuse to renew policies did not unconstitutionally impair obligation of contracts); *Smith v. Department of Ins.*, 507 So. 2d 1080 (Fla. 1987) (law requiring partial rebate of premiums on existing policies violates Contract Clause); *Reserve Life Ins. Co. v. La Follette*, 323 N.W.2d 173 (Wis. Ct. App. 1982) (statute requiring health insurer to offer coverage for chiropractic services impaired existing contractual relationships, but such impairment was not substantial); *American Mfrs. Mut. Ins. Co. v. Commissioner of Ins.*, 372 N.E.2d 520 (Mass. 1978) (upholding statute retroactively requiring policies to be rewritten at reduced rates and excess premiums rebated); *Health Ins. Ass'n of Am. v. Harnett*, 376 N.E.2d 1280 (N.Y. 1978) (law requiring health insurers to offer maternity coverage could not constitutionally be applied to existing health insurance policies). As a result, legislatures such as Maine's have become emboldened in their willingness to disregard legitimate contractual expectations.

If allowed to stand, the decision below will confirm the death of the Contract Clause as a meaningful limit on the power of states to modify the contract rights and

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[5] Tribe, American Constitutional Law (2d ed. 1988) §§ 9-11.

obligations of private parties. In light of the deference extended to the legislature by the Maine court, it will be necessary only to pay lip service to a broad public cause and the unfettered right to destroy private contracts will be won.

I.

RETROACTIVE APPLICATION OF LEGISLATION REQUIRING A PROVIDER OF HEALTH INSURANCE TO COVER PREEXISTING MEDICAL CONDITIONS SEVERELY IMPAIRS THE CONTRACTS BETWEEN THE PROVIDER AND ITS POLICYHOLDERS.

The Maine court correctly recognized that "the first inquiry must be whether the state law has, in fact, operated as a substantial impairment of a contractual relationship." *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978). The court then decided it could cut short the first stage of its Contract Clause analysis by simply assuming the impairment to American Republic to be substantial. This was improper. Before moving on, the court was obligated to assess the extent of the substantial impairment. That assessment determines the level of scrutiny to be applied in the following stages. As stated in *Allied Structural Steel*:

> The severity of the impairment measures the height of the hurdle the state legislation must clear. Minimal alteration of contractual obligations may end the inquiry at its first stage. Severe impairment, on the other hand, will push the inquiry to a careful examination of the nature and purpose of the state legislation.

Id., at 245 (citation omitted); *see Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983) ("The severity of the impairment is said to increase the level of scrutiny to which the legislation will be subjected."); *United States Trust Co. v. New Jersey*, 431 U.S. 1, 27 (1977) ("The extent of impairment is certainly a relevant factor in determining its reasonableness."); *cf. Keystone Bituminous Coal Ass'n v. DeBenedictis*, 480 U.S. 470, 504 (1987) ("We agree that the statute operates as a 'substantial impairment of a contractual relationship,' . . . and therefore proceed to the asserted justifications for the impairment.") (citation omitted); *Calfarm Ins. Co. v. Deukmejian*, 771 P.2d 1247, 1262 (Cal. 1989) ("We begin by assessing the severity of the impairment, since that assessment 'measures the height of the hurdle the legislation must clear'. . . . In the present case the impairment, while not so low as to escape constitutional scrutiny, is relatively moderate and restrained, and the hurdle correspondingly low.").

Had the Maine court completed the first stage analysis, it would have found the impairment to be severe. Indeed, the opinion in *Allied Structural Steel* used retroactive legislative tampering with insurance risks as an illustration of the severest kind of impairment. There, the plaintiff challenged a statute that materially increased the cost of its pension plan by requiring it to fund the plan so as to fully vest employees with ten years seniority. The Court compared this to an impairment of an insurance contract:

> "These [pension] plans, like other forms of insurance, depend on the accumulation of large sums to cover contingencies. The amounts set

> aside are determined by a painstaking assessment of the insurer's likely liability. Risks that the insurer foresees will be included in the calculation of liability, and the rates or contributions charged will reflect that calculation. The occurrence of major unforeseen contingencies, however, jeopardizes the insurer's solvency and, ultimately, the insureds' benefits. Drastic changes in the legal rules governing pension and insurance funds, like other unforeseen events, can have this effect."

Allied Structural Steel, 438 U.S. at 246-47 (quoting *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702, 721 (1978) (alteration in original).

By retroactively canceling exclusions for risks virtually certain to be experienced, section 2850(2) immediately and drastically increased the obligation of American Republic beyond the level it had agreed to accept, beyond the level on which its premium had been based and its reserve set aside, and even beyond the level at which it could hope to recover its loss through an increase in premiums. As made clear by the opinion in *Allied Structural Steel*, such an impairment can only be described as severe. If the Maine court had made the required assessment of the extent of the substantial impairment, it would not have been able to gloss so lightly over the second and third stages of the Contract Clause analysis.

II.

MAINE CANNOT SHOW A LEGITIMATE AND SIGNIFICANT PUBLIC PURPOSE BEHIND THE RETROACTIVE APPLICATION OF SECTION 2850(2).

The second stage of modern Contract Clause analysis requires that the State "have a significant and legitimate public purpose behind the regulation such as the remedying of a broad and general social or economic problem." *Energy Reserves Group*, 459 U.S. at 411-12 (citation omitted).

The entirety of the Maine court's treatment of this stage consumes only three sentences:

> We look to the plain language of a statute to discern "the real purpose of the legislation," which in this case reveals an intent to improve access to adequate health care. Such a public purpose cannot be considered other than significant and legitimate. The Legislature has determined that requiring coverage for preexisting conditions will reduce the number of persons without coverage and increase the availability of medical treatment.

App. 5-6 (state court citations omitted).

It is hardly surprising that such superficial consideration misses the mark. The question is not whether the legislation as a whole serves a broad public purpose, but whether the same can be said of its retroactive application. This was recognized by the Maine superior court, which observed that the Bureau of Insurance had "failed to identify a significant and legitimate public purpose behind the retroactive application of section 2850." App.

13. Regardless of whether the Act's prospective application would serve to broaden the availability of health care, the superior court found that its retroactive application "will have the effect of narrowing the availability of medical insurance to citizens of Maine." App. 13. The court's finding may have been based in part on a surprising concession from the superintendent, who had stated that "Perhaps American Republic is correct that the particular law that was enacted actually retards rather than advances that purpose." (Brief of superintendent submitted to Maine superior court, p. 12.)

More fundamentally, even if the retroactive application of section 2850(2) could be said to serve some good purpose, it could not possibly be the sort of broad public purpose required under the Contract Clause. There is no evidence in the record that the retroactive application of section 2850(2) affected anyone other than American Republic and its policyholders. The superintendent does not, and cannot, contend that there were other providers of similar guaranteed renewable health insurance in Maine. Thus, section 2850(2) is very similar to the pension statute in *Allied Structural Steel* where the Court found:

> But whether or not the legislation was aimed largely at a single employer, it [the statute] clearly has an extremely narrow focus. It applies only to private employers who have at least 100 employees, at least one of whom works in Minnesota, and who have established voluntary private pension plans, qualified under § 401 of the Internal Revenue Code. And it applies only when such an employer closes his Minnesota office or terminates his pension plan. Thus, this law can hardly be characterized, like the

> law at issue in the Blaisdell case, as one enacted to protect a broad societal interest rather than a narrow class.

Allied Structural Steel, 438 U.S. at 248-49 (footnotes omitted).

Certainly it cannot seriously be contended that retroactive legislation affecting only one insurance provider and several hundred insureds remedies "a broad and general social or economic problem," a requirement consistently recognized in this Court's modern Contract Clause opinions.

III.

IF IT WERE NECESSARY TO CONSIDER WHETHER THE ADJUSTMENT OF THE RIGHTS AND RESPONSIBILITIES OF THE CONTRACTING PARTIES HAD BEEN BASED UPON REASONABLE CONDITIONS AND WAS APPROPRIATE TO A PUBLIC PURPOSE, RETROACTIVE APPLICATION OF SECTION 2850(2) WOULD FAIL THIS TEST AS WELL.

Had the Maine Supreme Judicial Court properly performed the first two stages of its Contract Clause analysis, it would have been unnecessary to reach the third and final stage. Lacking a sufficiently broad public purpose, there would have been no need to consider whether the adjustment of contractual rights and obligations was reasonable. Still, it is constructive to subject the retroactive application of section 2850(2) to an appropriate third stage analysis.

Successful consideration of this stage was doomed from the start by the court's earlier failure to gauge the

severity of the contract impairment. This left the court with no understanding of the level of scrutiny it was required to apply. Not surprisingly, the court chose again to defer to the legislature, going so far as to observe that, "Even in the absence of legislative findings, the existence of facts supporting the legislative judgment is to be presumed." App. 6.

This excessively deferential attitude conflicts with the clear teaching of *Allied Structural Steel*:

> Despite the customary deference courts give to state laws directed to social and economic problems, "[l]egislation adjusting the rights and responsibilities of contracting parties must be upon reasonable conditions and of a character appropriate to the public purpose justifying its adoption." . . . Severe impairment . . . will push the inquiry to a careful examination of the nature and purpose of the state legislation.

Allied Structural Steel, 438 U.S. at 244-45, (quoting *United States Trust Co. v. New Jersey*, 431 U.S. 1, 22 (1977)).

Almost as an afterthought, the Maine court added that "section 2850(2) is based on reasonable conditions because it allows insurers to exclude preexisting conditions for limited periods and because it does not prohibit them from charging higher premiums to recover any losses." App. 6. As applied to American Republic's guaranteed policies, neither statement is accurate. For most of its insureds, American Republic was unable to exclude coverage of a preexisting condition for even a day.[6]

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[6] This would be true for any insured whose policy was first issued six months, or in some cases twenty-four months, before the next renewal date after December 1, 1990.

Wentworth is an example. As for charging higher premiums, the fact this is not prohibited by the statute is little consolation to American Republic, which is already effectively precluded from recovering the losses through premium increases.[7] Moreover, relying on future premium increases to justify retroactive legislation is particularly inappropriate in a regulated industry, as shown by subsequent events in Maine. In 1993, all insurers were required to revise their rating plans to achieve so-called community rates.

The Maine court was required to focus on the reasonableness of "the adjustment of 'the rights and responsibilities of [the] *contracting parties*' " caused by the retroactive application of section 2850(2). *Energy Reserves Group*, 459 U.S. at 412 (quoting *United States Trust Co.*, 431 U.S. at 22) (emphasis added). Instead, the court gave passing consideration to the effect on insurers generally of section 2850(2) applied as a whole.

A properly focused "third stage" analysis would have found a severe adjustment of American Republic's responsibilities and no counterbalancing adjustment of its rights. With no realistic hope of recovering the cost, American Republic was simply ordered to retroactively provide coverage of substantial medical expenses it had been under no previous obligation to pay. This is a constitutional "taking" of the rankest sort. *See Allied Structural Steel*, 438 U.S. at 241 n.12; *United States Trust Co.*, 431 U.S. at 19 n.16 ("Contract rights are a form of property and as

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[7] See discussion at pp. 5-6, *supra*.

such may be taken for a public purpose provided that just compensation is paid.") (citations omitted).

Even if premiums could be raised, this would only defeat the supposed purpose of section 2850(2), which the Maine court charitably assumed to be "an intent to improve access to adequate health care." App. 5. The insureds whose premiums American Republic would have to raise are the very people who chose to avoid that extra cost by excluding coverage for preexisting conditions. Retroactive application would entail very substantial premium increases of 25 to 100 percent, depending on the class over which the extra costs are distributed. Increases of this magnitude among an already cost conscious group of policyholders would normally drive many of them away from health insurance entirely.[8]

Appropriate scrutiny under the Contract Clause analysis developed by this Court leads inescapably to the

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[8] Even when applied prospectively, it is doubtful Section 2850(2) served the lofty purpose ascribed to it by the court. The principal effect of Section 2850(2) was to eliminate a choice that individual policyholders could make to acquire the only insurance they could afford or that insurers were willing to offer them. Allowing the exclusion of high risk conditions lowered the cost of insurance and in many cases made it available when otherwise, as the superintendent acknowledged, "coverage . . . would likely have been denied to them at any price." (Brief of superintendent submitted to Maine supreme court, p. 19.) Until the Maine Insurance Code was substantially amended in 1993 to require all health insurers to guarantee coverage to all applicants, insurers were free to reject applications from high risk individuals. *See* Me. Pub. L. 1993, ch. 477, § C-1.

conclusion that the severe impairment imposed by retroactive application of section 2850(2) cannot be justified by the purpose and nature of the statute.

CONCLUSION

For all of the above reasons, American Republic Insurance Company respectfully requests that its Petition for Writ of Certiorari be granted.

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EXHIBIT "A"

MAINE SUPREME
JUDICIAL COURT

Reporter of Decisions
Decision No. 6999
Law Docket No.
Ken-93-626

AMERICAN REPUBLIC INSURANCE COMPANY

v.

SUPERINTENDENT OF INSURANCE

Argued April 29, 1994
Decided September 21, 1994

Before WATHEN, C.J., and ROBERTS, GLASSMAN, CLIFFORD, RUDMAN, and DANA, JJ.

ROBERTS, J.

The Superintendent of Insurance appeals from a judgment entered in the Superior Court (Kennebec County, *Chandler, J.*) vacating the Superintendent's decision and declaring 24-A M.R.S.A. § 2850(2) (Supp. 1993) unconstitutional as applied to guaranteed renewable individual health insurance policies issued by American Republic Insurance Company before the statute's effective date. The Superintendent argues that retroactive application of section 2850(2) does not result in an unconstitutional impairment of contract.[1] Although American Republic may have suffered a substantial impairment of

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[1] The United States Constitution provides that "No State shall . . . pass any . . . Law impairing the Obligation of Contracts." U.S. Const. art. I, § 10. Article I, section 11 of the Maine Declaration of Rights states that "The Legislature shall pass no . . . law impairing the obligation of contracts."

its contracts, section 2850(2) has a significant and legitimate public purpose, and the adjustment of the parties' rights and responsibilities are reasonable and of a character appropriate to that purpose. Accordingly, we find no constitutional infirmity and vacate the judgment.

American Republic is an Iowa corporation registered to do business and licensed to provide insurance in Maine. As part of its business in this state, the company issues guaranteed renewable health insurance policies to individuals whereby it must renew the policy for the life of the insured so long as the premiums are paid. Benefits may not be changed without the consent of the insured, and the premium may be changed only pursuant to a uniform schedule based on the insured's age or if the change applies to the entire class of policyholders to which the insured belongs.

In the past American Republic routinely excluded identified health conditions from coverage when it determined that an individual had a high level of risk for a particular condition. In 1990, however, the Legislature enacted 24-A M.R.S.A. § 2850(2), which prohibits insurers from including in individual health insurance policies

> a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment.

P.L. 1989, ch. 867, § 8.[2] Section 2850(2) applies to all individual health insurance policies "executed, delivered,

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[2] The Legislature significantly amended section 2850(2) in 1993. *See* 24-A M.R.S.A. § 2850(2) (Supp. 1993) (effective Dec. 1,

issued for delivery, or renewed" in Maine on or after December 1, 1990. P.L. 1989, ch. 867, § 10. A policy was deemed to be renewed no later than the next yearly anniversary of the contract date. *Id.*

In September 1991, Herbert Wentworth of Corinth filed a complaint with the Bureau of Insurance, challenging American Republic's failure to remove a preexisting condition exclusion from his guaranteed renewable policy. The policy, which was issued in June 1988, excluded coverage for cataracts based on Wentworth's disclosure that his doctor had observed them developing in 1987. In response to Wentworth's complaint, the Bureau ordered American Republic to remove the exclusion.

American Republic requested a hearing before the Superintendent, seeking an exception from section 2850(2) for its guaranteed renewal policies. The Superintendent denied the request, concluding that even though section 2850(2) forced American Republic to pay for treatment of previously excluded conditions, there was no constitutional violation because the company could seek and obtain a premium increase.

American Republic sought judicial review in the Superior Court pursuant to M.R. Civ. P. 80C. The court concluded that American Republic's inability to cancel or refuse to renew Wentworth's policy resulted in increased contractual obligations. Rejecting the Superintendent's argument that the statute furthered the legitimate public

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1993); P.L. 1993, ch. 477, § A-15. All references to section 2850(2) in this opinion are to the provision in effect before the 1993 amendment.

purpose of broadening the availability of health care, the court vacated the Superintendent's decision. This timely appeal followed.

On an appeal from the Superior Court's review of an administrative decision, we review the agency's decision directly for an abuse of discretion, errors of law, or findings unsupported by the evidence. *International Paper Co. v. Board of Envtl. Protection*, 629 A.2d 597, 599 (Me. 1993). The construction of a statutory scheme is a question of law for the court. *Spiller v. State*, 627 A.2d 513, 515 (Me. 1993). Legislative enactments are presumed constitutional, and the party challenging a statute's constitutionality bears the burden of proof to the contrary. *Id.*

I.

In order to determine if the application of a statute results in an unconstitutional impairment of a contract, the Supreme Court has developed a three-part test. The threshold question is whether the law "operate[s] as a substantial impairment of a contractual relationship." *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411 (1983) (quoting *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978)). If so, the State must have "a significant and legitimate public purpose" for the regulation, such as remedying a broad, general social problem. *Id.* at 411-12. In addition, the adjustment of the contracting parties' rights and responsibilities that results from the new law must be based on reasonable conditions and "of a character appropriate" to the purpose that justified its adoption. *Id.* at 412 (quoting *United States Trust Co. of New York v. New Jersey*, 431 U.S. 1, 22 (1977)).

The question whether section 2850(2) operated as a substantial impairment of American Republic's contractual obligations has three components: (1) whether there was a contractual relationship; (2) whether the new law impaired that relationship; and (3) whether the impairment was substantial. *General Motors Corp. v. Romein*, 117 L. Ed. 2d 328, 337 (1992). The first two components are not in dispute, inasmuch as the Superintendent concedes that section 2850(2) increases American Republic's obligations under its guaranteed renewable policies. As to the third, the Superintendent contends that the degree of impairment is not substantial because of American Republic's ability to raise its premiums to compensate for higher costs, and because regulation in the health insurance field was foreseeable. We assume without deciding that in the case of American Republic's guaranteed renewable contracts the impairment is substantial.

II.

Despite the assumed substantial impairment, if section 2850(2) has "a significant and legitimate public purpose," it may yet survive constitutional scrutiny. *Energy Reserves*, 459 U.S. at 411. We look to the plain language of a statute to discern "the real purpose of the legislation," *Fraser v. Barton*, 628 A.2d 146, 148 (Me. 1993) (quoting *Mahaney v. State*, 610 A.2d 738, 741 (Me. 1992)), which in this case reveals an intent to improve access to adequate health care. Such a public purpose cannot be considered other than significant and legitimate, *see Calfarm Ins. Co. v. Deukmejian*, 771 P.2d 1247, 1250, 1262-63 (Cal. 1989). The Legislature has determined that requiring coverage

for preexisting conditions will reduce the number of persons without coverage and increase the availability of medical treatment.

III.

The final step in the *Energy Reserves* analysis is to determine if the adjustment of contractual rights and responsibilities caused by section 2850(2) is based on reasonable conditions and is "of a character appropriate" to the purpose of broadening the availability of health care. 459 U.S. at 412 (citation omitted). In reviewing economic and social legislation as provided by section 2850(2), we defer to the Legislature's judgment regarding the necessity for and reasonableness of the statute. *United States Trust Co.*, 431 U.S. at 22-23.

> Even in the absence of legislative findings, the existence of facts supporting the legislative judgment is to be presumed, for regulatory legislation is not to be pronounced unconstitutional unless in the light of the facts made known or generally assumed it is of such a character as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators.

Maine Milk Comm'n v. Cumberland Farms Northern, Inc., 160 Me. 366, 380, 205 A.2d 146, 153 (1964), *appeal dismissed*, 380 U.S. 521 (1965).

The Superintendent contends that section 2850(2) is based on reasonable conditions because it allows insurers to exclude preexisting conditions for limited periods and because it does not prohibit them from charging higher premiums to recover any losses. 24-A M.R.S.A. 2850(2).

We agree, although the ability to raise premiums is circumscribed by statute. *See* 24-A M.R.S.A. §§ 2736 to 2736-B (1990). *Cf. Calfarm*, 771 P.2d at 1262-63 (no constitutional infirmity in statute that required auto insurance renewal, but guaranteed insurers fair and reasonable rates). Moreover, section 2850(2) is designed to achieve its goal of greater access to adequate health care. Allowing for the appropriate deference to legislative judgment, the means selected are "of a character appropriate" to the purpose behind section 2850(2), and accordingly, it does not violate the Contract Clause of either the federal or the state constitution. *See Keystone Bituminous Coal Ass'n v. DeBenedictis*, 480 U.S. 470, 506 (1987) (legislation requiring coal companies to repair mining damages or pay costs of repairs served public purpose of deterring mining operations that severely affected surface).

The entry is:

Judgment vacated.

Remanded for the entry of a judgment in favor of the Superintendent of Insurance.

All concurring.

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NOTICE: Readers are requested to notify the Reporter of Decisions, Box 368, Portland, Maine 04112, of any typographical or other formal errors in this opinion.

EXHIBIT "B"

STATE OF MAINE
KENNEBEC, SS.

SUPERIOR COURT
CIVIL ACTION
DOCKET NO. CV-92-403

AMERICAN REPUBLIC INSURANCE COMPANY,
Plaintiff,

v.

SUPERINTENDENT OF INSURANCE,
Defendant.

OPINION AND ORDER

This matter is before the court on an appeal from a Decision and Order of the Superintendent of Insurance, *In re: American Republic Insurance Co.*, No. INS-92-31, pursuant to Rule 80C. Finding the retroactive application of Title 24-A M.R.S.A. § 2850 in violation of the contract clauses of the Maine and federal constitutions, the court vacates the Superintendent's order.

American Republic Insurance Company issued Mr. Herbert Wentworth policy #6085749 with an effective date of June 7, 1988. Because Mr. Wentworth indicated in his application that a doctor had noticed the beginning of cataracts, the policy included a lifetime rider excluding coverage for cataracts. The health insurance policy is "guaranteed renewable," and it states:

> We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period. While this policy is in force,

> we cannot change its benefits without your consent.

By the terms of the policy, American Republic must honor its obligations under the policy as long as Mr. Wentworth pays the premium. The policy allows American Republic to increase its premium rates at each renewal. Title 24-A M.R.S.A. § 2736 provides that the rates will be approved for use within 60 days, unless the Bureau finds them to be "excessive, inadequate or unfairly discriminatory."

On April 19, 1990, Title 24-A M.R.S.A. § 2850 was enacted as part of Public Law 1989, ch. 867, "An act to Insure Continuity of Health Insurance Coverage." Section 2850 provides:

> An individual policy issued by an insurer may not impose a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation.

Accompanying the Chapter 867, was the applicability clause, which provided:

> Title 24-A, section 2850 applies to all policies and contracts executed, delivered, issued for delivery, or renewed in this State on or after December 1, 1990. . . . For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

On August 5, 1991, counsel for American Republic sent a letter to the Superintendent of Insurance requesting that American Republic's guaranteed renewable individual

health insurance policies be excepted from the requirements of section 2850 because such application would result in an "impairment of an obligation of contract in violation of Article I, Section 10 of the United States Constitution."

On September 2, 1991, Mr. Wentworth filed a consumer complaint report with the Maine Bureau of Insurance, indicating that American Republic had failed to remove the rider attached to his policy. On September 12, 1991, an attorney from the Bureau wrote to American Republic concerning Mr. Wentworth's complaint, and American Republic responded referring the Bureau to the August 5, 1991, letter. On October 14, 1991, counsel for American Republic again requested an exception to the application of Section 2850, and the Bureau denied the request on October 25, 1991. On November 13, 1991, American Republic requested a hearing on the Bureau's decision.

A hearing was held on February 25, 1992, at which time American Republic raised its constitutional claims. In a Decision and Order, dated July 23, 1992, the Superintendent of Insurance concluded that "American Republic Insurance Company violated Title 24-A M.R.S.A. § 2850 by failing to remove a lifetime rider for cataracts from major medical policy #6085749 issued to Herbert Wentworth on June 7, 1988." Finding it unnecessary to address the extensive arguments presented by the parties as to the issue of whether the application of the statute constituted an impairment of the contract, the Superintendent concluded that although "[t]here is no question, and the Staff readily concedes this fact, that American Republic will

have to pay for treatment of previously excluded preexisting conditions if forced to remove the rider on Mr. Wentworth's policy," the statute allows American Republic to apply for rate increases to cover this cost. Because the statute "provides an avenue for redress of any inequity from the retroactive application of Section 2850," the Superintendent concluded that application of Section 2850 does not constitute impairment of contract. On August 26, 1992, American Republic filed a petition for review of final agency action.

Finding it dispositive of the case, the court first addresses American Republic's argument that retroactive application of Section 2850 violates the Contract Clauses of the Maine and Federal Constitutions. Both the provisions of the Maine statutes and the parties recognize that the insurance policy between American Republic and Mr. Wentworth is a contract. Applying the three part test developed by the United States Supreme Court in *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 410-13 (1983), the court must first determine whether there is "a substantial impairment of a contractual relationship." *Id.* at 411 (*quoting Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978)). Because American Republic has no ability to cancel or to refuse renewal as long as the premium is paid, retroactive application of Section 2850 essentially forces American Republic to increase its obligations under the contract by paying any claims on medical conditions originally excluded by the policy coverage. The court finds such an increase in obligation a substantial impairment of the contract. The court does not find that the statute's and policy's allowance of an increase in rates to cover American

Republic's increased obligation dictates a finding that no impairment exists or that the impairment is not substantial. Such factors should be considered in determining whether the impairment was reasonable, a consideration in the third and final step of the *Energy Reserves* analysis.

Finding that a substantial impairment of the contract exists, the State "in justification, must have a significant and legitimate public purpose behind the regulation." *Id.* at 411-12 (*quoting United States Trust Co. v. New Jersey*, 431 U.S. 1, 22 (1977)). In its brief, the Superintendent identifies "broadening the availability of health care" as the State's legitimate public purpose. The court finds that although broadening the availability of health care is *a* legitimate public purpose, it can not be *the* purpose behind enacting section 2850 and retroactively applying it to the guaranteed renewable policies issued by American Republic. Instead of broadening the availability of health care, this application of section 2850 will have the affect of narrowing the availability of medical insurance to citizens of Maine. Because the Bureau has failed to identify a significant and legitimate public purpose behind the retroactive application of section 2850, the court does not reach the third step in the *Energy Reserves* analysis and finds that the retroactive application of section 2850 to the lifetime guaranteed renewable policies constitutes an impairment of contract under the Maine and Federal Constitutions.

The entry will therefore be:

Appeal **GRANTED.** The Decision and Order of the Superintendent of Insurance is

VACATED. Case remanded to the Superintendent of Insurance for further proceedings consistent with this order.

DATED: July 28 , 1993

/s/ Bruce W. Chandler
BRUCE W. CHANDLER
JUSTICE, SUPERIOR COURT

EXHIBIT "C"

John R. McKernan, Jr.
Governor

Brian K. Atchinson
Superintendent

(Seal)

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE
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STATE OF MAINE
DOCKET NO. INS 92-31

IN RE:)
AMERICAN REPUBLIC) **DECISION AND ORDER**
INSURANCE COMPANY)

On February 25, 1992, a Notice of Hearing was issued to American Republic Insurance Company pursuant to Title 24-A M.R.S.A. § 211, 229, and 2850. Pursuant to Title 24-A M.R.S.A. § 210, Kathryn E. Davis, Esq. was delegated by the Superintendent of Insurance to act as presiding officer in this matter. A hearing was held on May 5, 1992, for the purpose of determining whether or not American Republic Insurance Company violated 24-A M.R.S.A. § 2850 by attaching a lifetime rider for cataracts to a major medical policy issued to Herbert Wentworth.

Having carefully considered the evidence in this case, the Superintendent concludes that American Republic Insurance Company violated Title 24-A M.R.S.A. § 2850 by failing to remove a lifetime rider for cataracts from major medical policy #6085749 issued to Herbert Wentworth on June 7, 1988.

FINDINGS OF FACT

I. The Superintendent takes official notice of Bureau of Insurance Bulletins, 180, 189, and 191.

II. The Superintendent finds that the following facts have been proven by a preponderance of the evidence adduced at the hearing:

1. Herbert Wentworth applied for an American Republic Insurance Company guaranteed renewable individual health insurance policy on May 18, 1988. In his application, Mr. Wentworth indicated that his eye doctor found the beginnings of a cataract in one or both of his eyes in 1987. American Republic issued policy #6085749 to Mr. Wentworth with an effective date of June 7, 1988. The policy included an endorsement excluding coverage for cataracts.

2. On September 2, 1991, Herbert I. Wentworth filed a consumer complaint report with the Maine Bureau of Insurance, complaining that American Republic Insurance Company violated 24-A M.R.S.A. § 2850 by failing to remove a rider attached to his policy, which excluded coverage for cataracts of either or both eyes.

3. On September 12, 1991, Alison Bane, attorney for the Bureau, wrote to American Republic regarding the complaint. American Republic responded on September 20, 1991, by referring Ms. Bane to an August 5, 1991, letter addressed to the Superintendent of Insurance. In the August letter, Bradley E. Allen, counsel for the company, requested that American Republic's guaranteed renewable individual health insurance policies be excepted from the requirements of Section 2850 because such application of the law would result in an "impairment of an

obligation of contract in violation of Article I, Section 10 of the United States Constitution."

4. On October 14, 1991, Mr. Allen again wrote to the Superintendent requesting an exception. On October 25, 1991, Alison Bane wrote to American Republic denying the exception. On November 13, 1991, American Republic wrote to the Bureau requesting a hearing on Ms. Bane's decision.

5. On April 19, 1990, the Governor of the State of Maine approved Public Law Chapter 867, An Act to Insure Continuity of Health Insurance Coverage. As part of that law, Title 24-A M.R.S.A. § 2850 was enacted. Section 2850 prohibits any preexisting condition exclusion period which exceeds six months, except in the case of conditions requiring ongoing medical observation or treatment on the effective date of the coverage, in which case the limit is two years. Section 2850 requires insurers to amend any policy having a preexisting condition exclusion or an exclusionary rider in any policy renewing on or after December 1, 1990, upon the first renewal after the date.

6. American Republic has failed to remove a lifetime rider for cataracts from major medical policy # 6085749 issued to Herbert Wentworth on June 7, 1988.

7. American Republic may file for rate increases adequate to offset the losses that may be incurred by the removal of preexisting condition exclusions in existence prior to enactment of Section 2850.

8. Herbert Wentworth's guaranteed renewable health insurance policy provides that the company may increase rates in the future.

9. American Republic's guaranteed renewable contract with Herbert Wentworth does not fall under any of the exceptions enumerated in Section 2850.

10. The Bureau of Insurance introduced legislation, L.D. 1821, in May, 1991, which would have repealed the retroactive effect of Section 2850. The proposed legislation failed to win legislative approval.

CONCLUSIONS OF LAW

1. The Continuity of Health Insurance Coverage Act prohibits individual health insurance policies from imposing a preexisting condition exclusion period of more than 6 months or up to 24 months for any preexisting condition that requires ongoing medical observation or treatment. Title 24-A M.R.S.A. § 2850.

2. Section 2850 applies to all policies "executed, delivered, issued for delivery, or renewed" in the State of Maine on or after December 31, 1990, including guaranteed renewable policies. P.L. 1989, ch. 867, § 10.

3. Section 2850 excepts long-term care policies as defined in 24-A M.R.S.A. Section 5051, long-term disability policies, Medicare supplement policies and policies designed to cover specific diseases, hospital indemnity or accidental injury only; it does not except policies simply because they are "guaranteed renewable policies."

4. P.L. 1989, ch. 867, § 10 provides that all contracts, including guaranteed renewable individual health insurance policies, are deemed to be renewed no later than the next yearly anniversary of the contract date.

5. Title 24-A M.R.S.A. § 2850 does not constitute an unconstitutional impairment of contract when applied to guaranteed renewable individual health insurance policies.

6. The retroactive application of Section 2850 does not contravene the Due Process Clause of Article I, Section 6-A of the Maine Constitution and the 5th and 14th Amendments of the United States Constitution.

7. "Preexisting conditions," as defined in Section 2848 includes any condition specifically identified in an application which is then excluded in the contract because it was identified in the application.

DISCUSSION

It is clear that Title 24-A M.R.S.A. Section 2850 applies to Herbert Wentworth's policy with American Republic Insurance Company. In addition to the clear language in the effective date clause of the Continuity Act, Bulletin 191 further clarifies that "any policy renewing on or after December 1, 1990, for which a preexisting condition exclusion or exclusionary rider is still in effect, and which does not comply with the new requirements, must be amended as of the renewal date." Because Mr. Wentworth's preexisting condition exclusion was imposed on June 7, 1988, and therefore had been in effect for more than two years at the time of renewal, the

exclusion became invalid on June 7, 1991, the first renewal after the effect of the new law.

EVIDENTIARY ISSUES

American Republic has challenged the admission of certain evidence presented by the Staff. In its Post Hearing Memorandum dated May 20, 1992, American Republic challenges the relevance and admissibility of the testimony of Richard Diamond, Bureau Actuary, who appeared as a witness on behalf of the Bureau. Counsel for American Republic objected to testimony by Mr. Diamond to the extent it was intended to provide evidence of legislative intent.

Staff contends that Mr. Diamond's testimony was not presented for the purpose of establishing legislative intent in enacting the continuity law. Staff has indicated that it does not believe there is any issue of ambiguity as regards the law. I agree with this assertion. The provisions of law at issue in this case are clear.

Mr. Diamond's testimony is helpful in deciding this matter in two ways. First, Mr. Diamond's testimony pertaining to the Bureau's unsuccessful attempt to introduce L.D. 1821, in May, 1991, which would have repealed the retroactivity effect of Section 2850 supports the conclusion that Section 2850 is not an unconstitutional impairment of contract. Secondly, Mr. Diamond's testimony is useful for the purpose of providing information relative to American Republic's ability to file for rate increases.

I find no reason to find Mr. Diamond's testimony inadmissible. Though the importance of his testimony is

limited, it is not necessary that a fact finder use every portion of all testimony in deciding a case; in fact, American Republic agrees that portions of Mr. Diamond's testimony support arguments they have presented. There is no prejudice to respondent in allowing Mr. Diamond's testimony to remain on the record. Furthermore, though all facts presented may not be crucial to this Decision, a reviewing fact finder, analyzing this matter from a different perspective, may find other portions of Mr. Diamond's testimony useful.

Similarly, American Republic objects to the submission by Staff of an August, 1990, Consumer Reports Article which examines the current national health care crisis. This evidence is not necessary to a determination of any fact in this matter and it has not been relied upon in reaching any findings or conclusions of law. It cannot be said, however, that the contents of the exhibit are irrelevant; rather, the article provides helpful background information with respect to understanding issues relevant to enactment of laws like Maine's Continuity Act. Thus, there is no reason to remove the exhibit from the record.

PREEXISTING CONDITION DEFINITION

In its May 20 Post Hearing Memorandum, American Republic belatedly asserts that the condition excluded in Mr. Wentworth's policy is not a preexisting condition. This position is unsupported by the evidence. The facts show that Herbert Wentworth applied for an American Republic Insurance Company guaranteed renewable individual health insurance policy on May 18, 1988. He indicated in his application that his eye doctor discovered the

beginnings of a cataract in one or both of his eyes in 1987. American Republic issued policy # 6085749 to Mr. Wentworth with an effective date of June 7, 1988. The policy included an endorsement excluding coverage for cataracts. This was not an endorsement situation applied to all American Republic policyholders, nor was Mr. Wentworth chosen for his endorsement at random. There is no question that American Republic intended for Mr. Wentworth's endorsement to be an exclusion of a preexisting condition.

Furthermore, the company admits that Mr. Wentworth's exclusion was a preexisting condition in its Hearing Memorandum dated May 5, 1992. The company states that "It had been American Republic's practice to issue guaranteed renewable policies at premium rates favorable to the insured with negotiated waivers of *identified pre-existing conditions.*" (Page 3, emphasis added.)

IMPAIRMENT OF CONTRACT ISSUE

The initial response of American Republic to the Bureau Staff's request to remove Mr. Wentworth's waiver was that to do so would amount to an unconstitutional impairment of contract. Though both parties have presented extensive arguments and explored the case law in depth, I find it unnecessary to address those arguments in detail. It is clear that Section 2850 does not amount to an unconstitutional impairment of contract.

There is no question, and the Staff readily concedes this fact, that American Republic will have to pay for treatment of previously excluded preexisting conditions if forced to remove the rider on Mr. Wentworth's policy.

Therefore, the company may file amended rate information pursuant to Title 24-A M.R.S.A. § 2736. Unless the filed rates are "excessive, inadequate or unfairly discriminatory" or unless the filing in some other way violates the law, the rates may then be approved for use within 60 days. Title 24-A M.R.S.A. section 2736. At renewal time, Mr. Wentworth's rates may be modified, along with all other policies falling into the same class. This process as established by the Legislature, clearly does not amount to an unconstitutional impairment of contract, as it provides an avenue for redress of any inequity resulting from the retroactive application of Section 2850.

It should also be noted that the company knew, or should have known, in the spring of 1990 that this legislation had been approved by the Governor. American Republic could have taken steps at that time to insure that the phase out of preexisting conditions coincided with rate adjustments.

DUE PROCESS ARGUMENT

In its post hearing memorandum dated May 20, 1992, American Republic argues that application of Section 2850 retroactively to American Republic's guaranteed renewable policies, violates the Due Process Clause of Article I, Section 6-A of the Maine Constitution and the 5th and 14th Amendments of the United States Constitution. In its May 20th Memorandum, American Republic asserts that such application would deprive the company of property without compensation because it would have "no source of premium revenue to cover these increased costs . . . " (page 9). It is clear, however, and the company

admits, that it is free to file its increased rates for approval. Again, rates will be disapproved only if found to be "excessive, inadequate, or unfairly discriminatory." This process provides for a system of regulation that will allow companies to charge rates commensurate with the coverage being provided.

American Republic contends also that due process is violated because there is no rational connection between the effect of Section 2850 and the problem it was meant to address. There is no evidence on the record to support such an assertion.

American Republic also argues in its post hearing memorandum dated May 20, 1992, that application of Section 2850 would be confiscatory as it, "would have a decidedly adverse effect on the marketing of American Republic policies" such that "[t]he result is likely to be a sharp reduction in the amount of insurance American Republic writes in Maine." Changes in the law are often made that require insurance companies to modify contracts. If American Republic decides that it must withdraw from the health insurance arena in Maine because the legislature has changed the laws pertaining to sale of that insurance, the result is not confiscatory. Rather, it is merely a business decision in which the company chooses to leave because it does not think it economically feasible to continue. As Staff points out in its Post Hearing Response Memorandum, "a change in the rules regulating the sale of a particular insurance product may require a change in marketing strategies, but, considering all Maine licensed insurers are faced with the same change in rules brought about by Section 2850, any sharp reduction in the amount of insurance American Republic writes

in Maine will occur either as a result of a conscious choice on American Republic's part or as a failure on their part to respond competitively to a shifting regulatory framework."

THE APPLICABILITY CLAUSE

Finally, American Republic asserts that because guaranteed renewable policies are continuous policies with no expiration dates and because the parties consequently did not intend to enter into a new and independent insurance contract each time a payment was made, Mr. Wentworth's policy should be excepted from Section 2850. Although Section 2850 does provide a specific list of kinds of insurance policies that are excluded from the Continuity Act, it does not exempt guaranteed renewable health insurance policies. To the contrary, the applicability clause of the Continuity Act expressly provides when multi-year or "continuous" policies are deemed renewed. P.L. 1989, ch. 867, § 10.

IT IS HEREBY ORDERED that American Republic Insurance Company must remove the preexisting condition exclusion for cataracts from Mr. Wentworth's policy retroactively effective to June 7, 1991, and make payment on any claims Mr. Wentworth has incurred since that time as a result of treatment for the excluded condition.

This Decision and Order is a final agency action within the meaning of the Maine Administrative Procedure Act, unless it is vacated, modified, or superseded following a timely motion for reconsideration or

amended filing. It is appealable to the Superior Court in the manner provided in 24-A M.R.S.A. § 236 (Supp. 1990) and M.R. Civ. P. 80C. Any party to the hearing may initiate an appeal within thirty days after receiving this notice. Any aggrieved non-party whose interests are substantially and directly affected by the Superintendent's decision may initiate an appeal on or before September 1, 1992. There is no automatic stay pending appeal; application for stay may be made in the manner provided in 5 M.R.S.A. § 11004.

PER ORDER OF THE SUPERINTENDENT

BRIAN K. ATCHINSON

/s/ Kathryn E. Davis
Kathryn E. Davis, Esq.
Presiding Officer

Dated July 23, 1992

cc Brad Allen
7/28/92

EXHIBIT "D"

STATE OF MAINE Kennebec, ss.	SUPERIOR COURT Civil Action Docket No. _____
AMERICAN REPUBLIC INSURANCE COMPANY Plaintiff v. BRIAN K. ATCHINSON, Superintendent, of Professional and Financial Regulation Defendant	Complaint for Review of Final Agency Action

COUNT ONE

1. This is an action pursuant to Rule 80C and 5 M.R.S.A. Ch. 375 seeking review of an order of the Superintendent of the Bureau of Insurance.

2. Plaintiff American Republic is an Iowa corporation, having its principal place of business in Des Moines, Iowa. Plaintiff is registered and authorized to do business as an insurer in the State of Maine.

3. Defendant Brian K. Atchinson, is the Superintendent of the Bureau of Insurance, Maine Department of Professional and Financial Regulation. As such, he is authorized and empowered pursuant to 24-A M.R.S.A. § 211 and § 229 to enforce the provisions of Title 24-A M.R.S.A., and for that purpose to hold hearings and issue orders.

4. Laws, 1989, Ch. 867, enacted Title 24-A M.R.S.A. § 2850. This section prohibits insurers that issue individual health insurance from imposing preexisting condition exclusion periods longer than 6 months except that preexisting conditions requiring ongoing medical observation or treatment may be excluded for up to 24 months.

5. Laws, 1989, Ch. 867, Sec. 10, provided that Section 2850 of Title 24-A would apply to all policies and contracts of insurance renewed in Maine on or after December 1, 1990. It further provided that "all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date." Section 2850 was thereby made applicable to contracts of insurance existing at the date of its enactment, regardless what provisions those contracts might contain with respect to preexisting conditions, termination or renewal. Chapter 867 was enacted on April 7, 1990.

6. American Republic Insurance Company is now and for some time has been engaged in the business of entering into individual guaranteed renewable contracts of health insurance in Maine and elsewhere. Each such policy obligates American Republic, upon receiving payment of the designated premium, to renew the policy without change for the life of the insured person. Each such policy further provides that premiums may only be changed pursuant to a uniform schedule based on the age of the insured or pursuant to a premium change applicable to the entire class of insureds to which the policyholder belongs, within the state where the policy was issued. It was the practice of American Republic in appropriate cases to exclude identified health risks from coverage in policies issued to individuals determined to

have a high level of risk of those conditions for the purpose of keeping the cost of its policies at an affordable level. On the date of enactment of Chapter 867, American Republic had issued and had outstanding 432 such policies in Maine.

7. One of the American Republic policies issued and in force in Maine on the date of enactment of Chapter 867 had been issued to one Herbert Wentworth, of East Corinth, Maine. The Wentworth policy excluded coverage of treatment for cataracts in either eye, a condition for which Mr. Wentworth was known to be at risk since developing cataracts had been observed at the time his policy issued.

8. On or about September 2, 1991, Mr. Wentworth filed a consumer complaint with the Maine Bureau of Insurance against American Republic averring violation of 24-A M.R.S.A. § 2850 by failing to remove the exclusion of treatment for cataracts at the anniversary of his policy on June 7, 1991.

9. On or about February 25, 1992, the Bureau ordered hearing.

10. On May 5, 1992, a hearing on Mr. Wentworth's complaint was held.

11. On July 27, 1992, American Republic received the Bureau of Insurance's decision in this matter dated July 23, 1992, a copy of which is attached hereto as Exhibit A.

12. Exhibit A constitutes a final Agency action within the meaning of the Administrative Procedure Act, 5 M.R.S.A. Ch. 375.

13. Plaintiff was a party to the proceeding in which Exhibit A was issued and is aggrieved by defendant's action ordering American Republic to remove the preexisting condition exclusion for cataracts from Mr. Wentworth's policy retroactively effective June 7, 1991, and to make payment on any claims Mr. Wentworth has incurred since that time as a result of treatment for the excluded condition.

14. Plaintiff seeks relief upon the grounds that:

a) the Agency action was in violation of the Constitution of the United States and of this State in that i) Section 2850 as applied to American Republic's guaranteed renewable policies impairs the obligation of those contracts in violation of Article 1, Sec. 10 of the United States Constitution and Article 1, Sec. 11 of the Maine Constitution; ii) Section 285, as applied to American Republic's policies violates the due process clauses of Article 1, Sec. 6-A of the Main Constitution and the 14th Amendment to the United States Constitution.

b) the Agency action was affected by errors of law in that *inter alia* the record fails to show that the Wentworth policy contained a pre-existing conclusion.

c) the Agency action was arbitrary, capricious and characterized by abuse of discretion.

WHEREFORE, plaintiff requests the Court to enter an order reversing the action of the Bureau of Insurance.

COUNT TWO

15. Paragraphs 1 through 12 are incorporated in this Count Two.

16. In Exhibit A, the Bureau of Insurance concluded the following:

A. 24-A M.R.S.A. § 2850 applies to American Republic's guaranteed renewable policies that were in effect on the effective date of Section 2850 on December 1, 1990;

B. 24-A M.R.S.A. § 2850 is constitutional as applied to American Republic's guaranteed renewable policies that were in effect on the effective date of Section 2850; and

C. The Bureau of Insurance intends to enforce the applicability of Section 2850 to American Republic's guaranteed renewable policies by requiring American Republic to assume obligations not contained in the policies when Section 2850 became effective.

17. American Republic disagrees with the Bureau of Insurance's decision dated July 23, 1992.

18. There is a justiciable controversy between the Bureau of Insurance and American Republic as to the application of 24-A M.R.S.A. § 2850 to American Republic's guaranteed renewable policies in effect prior to December 1, 1990, when Section 2850 became effective, and this Court is authorized by 14 M.R.S.A. Ch. 707, to grant declaratory relief.

WHEREFORE, American Republic requests this court to enter a declaratory judgment that 24-A M.R.S.A. § 2850 is applicable to the guaranteed renewable policies issued by American Republic prior to its effective date, or in the alternative that Section 2850 is unconstitutional as applied to the guaranteed renewable policies issued by

American Republic prior to the effective date of Section 2850, and that the Bureau of Insurance cannot require American Republic to comply with Section 2850 by making American Republic assume obligations not contained in policies when Section 2850 was enacted.

Dated: August 25, 1992

Respectfully submitted,

/s/ Gordon H. S. Scott
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EXHIBIT "E"

Sec. 8. 24-A MRSA c. 36 is enacted to read:

CHAPTER 36

CONTINUITY OF HEALTH INSURANCE COVERAGE

§2848. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Group. "Group" means any of the types of groups under sections 2804 to 2808.

2. Preexisting conditions exclusion. "Preexisting condition exclusion" means an exclusion of benefits for a specified or indefinite period of time on the basis of one or more physical or mental conditions for which, preceding the effective date of enrollment:

A. A person experienced symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

B. A provider of health care services recommended or provided medical advice or treatment to the person.

3. Subgroup. "Subgroup" means an employer covered under a contract issued to a multiple employer trust or to an association.

4. Waiting period. "Waiting period" means a period of time after the effective date of enrollment during which a health insurance plan excludes coverage for the diagnosis or treatment of any or all medical conditions.

§2849. Continuity on replacement of group policy

1. Policies subject to this section. Notwithstanding any other provision of law, this section applies to all group policies, except group long-term care policies as defined in section 5051 or group long-term disability policies, issued by insurers or health maintenance organizations to policyholders who are obtaining coverage to replace coverage under a different contract or policy issued by any nonprofit hospital or medical service organization, insurer or health maintenance organization. For purposes of this section, the group policy issued to replace the prior contract or policy is the "replacement policy." The group contract or policy being replaced is the "replaced contract or policy."

2. Persons provided continuity of coverage under this section. This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy.

3. Prohibition against discontinuity. In a replacement policy subject to this section, an insurer or health maintenance organization may not, for any person described in subsection 2:

A. Request that the person provide or otherwise seek to obtain evidence of insurability;

B. Decline to enroll the person on the basis of evidence of insurability if the person is otherwise eligible for coverage; or

C. Impose a preexisting condition exclusion period or waiting period on that person, except as provided in this section.

4. Persons covered for fewer than 90 continuous days. Notwithstanding subsection 3, a person who was covered under the replaced contract or policy for fewer than 90 continuous days may be subject to a preexisting condition exclusion or waiting period in the replacement policy, provided the period is not longer than 90 days; and credit is given for satisfaction or partial satisfaction of the same or similar provisions under the replaced contract or policy.

5. Liability after discontinuance. The nonprofit hospital or medical service organization, insurer or health maintenance organization that issued the replaced contract or policy is liable after discontinuance of that contract or policy only to the extent of its accrued liabilities and extensions of benefits.

§2849-A. Extension of benefits for disabled persons

1. Policies subject to this section. This section applies to group policies that provide hospital or medical expense coverage and group policies that provide benefits for loss of time from work or specific indemnity during hospital confinement. This section does not apply to group policies providing coverage only for dental expense or to group long-term care policies as defined in section 5051 or group long-term disability policies.

2. Requirement. Every group policy subject to this section must provide a reasonable extension of benefits for a person who is totally disabled on the date the group policy is discontinued, or on the date coverage for a subgroup in the policy is discontinued. A premium may

not be charged during the period of extension. For a policy providing hospital or medical expense coverage, an extension of benefits provision is reasonable if it provides benefits for covered expenses directly relating to the condition causing total disability for at least 6 months following the effective date of discontinuance. For a policy providing benefits for loss of time from work or specific indemnity during hospital confinement, extension of benefits means that discontinuance of the policy during a disability has no effect on benefits payable for that disability or confinement.

3. Description of benefit extension. The extension of benefits provision must be described in all policies and group certificates. The benefits payable during any period of extension are subject to the regular benefit limits under the policy.

4. Liability after discontinuance. After discontinuance of a policy, the insurer or health maintenance organization remains liable only to the extent of its accrued liabilities and extensions of benefits. The liability of the insurer or health maintenance organization is the same whether the group policyholder or other entity secures replacement coverage from any insurer, nonprofit hospital or medical service organization or health maintenance organization, self-insures or forgoes the provision of coverage.

5. Rules. The superintendent shall adopt rules to define the term "total disability" for purposes of this section. The definition must identify persons who are unable, as a result of disability, to obtain comparable

alternative coverage through comparable employment or otherwise.

§2849-B. Continuity for individual who changes groups

1. Policies subject to this section. This section applies to all group policies issued by insurers or health maintenance organizations, except group long-term care policies as defined in section 5051 and group long-term disability policies.

2. Persons provided continuity of coverage. Except as provided in subsection 3, this section provides continuity of coverage for a person who seeks coverage under a group insurance or health maintenance organization policy if:

A. That person was covered under an individual or group contract or policy issued by any non-profit hospital or medical service organization, insurer, health maintenance organization, or governmental program such as Medicaid, the Maine Health Program, as established in Title 22, section 3189, or the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Section 1072, Subsection 4. For purposes of this section, the group policy under which the person is seeking coverage is the "succeeding policy." The group or individual contract or policy that previously covered the person is the "prior contract or policy"; and

B. Coverage under the prior contract or policy terminated within 3 months before the date the person enrolls or is eligible to enroll in the succeeding policy. A period of ineligibility for any

health plan imposed by terms of employment may not be considered in determining whether the coverage ended within 3 months of the date the person enrolls or would otherwise be eligible to enroll.

3. Exception for late enrollees. Notwithstanding subsection 2, this section does not provide continuity of coverage for a late enrollee. For purposes of this section, a "late enrollee" is a person who requests enrollment in a group plan following the initial enrollment period provided under the terms of the plan, except that a person is not a late enrollee if:

A. The request for enrollment is made within 30 days after termination of coverage under a prior contract or policy and the individual did not request coverage initially under the succeeding policy because that individual was covered under a prior contract or policy and coverage under that contract or policy ceased due to termination of employment, death of a spouse or divorce; or

B. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's plan and the request for coverage is made within 30 days after issuance of the court order.

4. Prohibition against discontinuity. Except as provided in this section, in a group policy subject to this section, an insurer or health maintenance organization must, for any person described in subsection 2, waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or

policy were still in effect. The succeeding policy is not required to duplicate any benefits covered by the prior contract or policy.

5. **Determination of benefits.** When a determination of benefits under the prior contract or policy is required, the issuer of the prior contract or policy shall, at the request of the issuer of the succeeding policy, furnish a statement of benefits available or pertinent information sufficient to permit verification of the benefit determination or the determination itself by the issuer of the succeeding policy. For purposes of this section, benefits of the prior contract or policy are determined in accordance with the definitions, conditions and covered expense provisions of that contract or policy rather than those of the succeeding policy. The benefit determination must be made as if coverage had not been replaced.

6. **Limit on premium increase.** For rating purposes, an insurer or health maintenance organization may not charge claims for preexisting conditions of any person subject to this section, during the first 12 months of employment of that person, directly to a group of fewer than 100 insured employees except to the extent that the resulting increase in the premium would be 10% or less. The insurer or health maintenance organization may pool any additional claims among all such groups and subgroups covered by that insurer or health maintenance organization. This requirement also applies to subgroups of fewer than 100 insured employees if the subgroup is treated as a separate unit for rating purposes.

§2850. Limitations on exclusion and waiting periods

1. Application. This section applies to individual policies subject to chapter 33, except long-term care policies defined in section 5051, long-term disability policies. Medicare supplement policies and policies designed to cover specific diseases, hospital indemnity or accidental injury only.

2. Limitation. An individual policy issued by an insurer may not impose a preexisting condition exclusion period of more than 6 months, except that the policy may exclude coverage for up to 24 months for any preexisting condition that, as of the effective date of the coverage, requires ongoing medical observation or treatment.

Sec. 9. 24-A MRSA §4210-A is enacted to read:

§4210-A. Continuity of health insurance coverage

Notwithstanding section 4210, the provisions of chapter 36 apply to health maintenance organizations.

Sec. 10. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after October 1, 1990. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

Sec. 11. Health insurance continuity task force. As soon as practicable after passage of this Act, the Superintendent of Insurance shall convene a task force to study all reasonable proposals to ensure continuous health

insurance coverage for as many citizens of this State as possible.

1. The health insurance continuity task force shall consist of 14 members as follows:

A. Four Legislators to be selected by the President of the Senate and the Speaker of the House of Representatives;

B. A representative of the Bureau of Insurance;

C. One representative of consumers, to be selected by the Consumers for Affordable Health Care;

D. One representative of employers, to be selected by the Maine Chamber of Commerce and Industry;

E. One employer that receives insurance through a multiple employer trust, to be selected by the Maine Chamber of Commerce and Industry;

F. One small business employer, to be selected by the Maine Merchants Association;

G. One representative of labor, to be selected by the Maine AFL-CIO;

H. One representative of commercial health insurers, to be selected by the Health Insurance Association of America;

I. One representative of nonprofit hospital or medical service organizations, to be selected by Blue Cross and Blue Shield of Maine;

K. One independent insurance agent with experience selling health insurance, to be selected jointly by the Independent Insurance

Agents Association of Maine, the Professional Insurance Agents of New England and the Maine Association of Life Underwriters; and

L. One member of the Special Select Commission on Access to Health Care, to be selected by the members of that commission.

Organizations that are required to select members for the task force shall submit their selections to the superintendent as soon as possible after passage of this Act. The superintendent shall appoint those persons to the task force and shall convene the first meeting of the task force as soon as possible after receiving the selections from the organizations.

2. Members of the task force are not entitled to compensation, except that, if authorized by the Legislative Council, legislative members of the task force may receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for expenses.

3. The issues to be addressed by the task force include, but are not limited to:

A. Rights of continuity for individual health insurance policyholders;

B. Limits on preexisting condition exclusions, riders, medical underwriting, and waiting periods;

C. Pooling, reinsurance and community rating for small business group and individual policies for spreading the costs of high-risk individuals who are provided continuous coverage;

D. Exclusions by industry or occupation; and

E. The economic impact of the proposed changes, including actuarial projections that account for reserve policies, costs of underwriting, administration, legal costs, marketing costs such as advertising and sales commissions, investment income and profit margins by product line, company and by industry.

4. The Bureau of Insurance shall provide staff assistance to facilitate the work of the task force and the collection of appropriate and necessary data from insurers and to draft any recommended legislation of the task force.

5. The task force shall submit any recommended legislation to the Joint Standing Committee on Banking and Insurance by January 1, 1991.

FISCAL NOTE

The Bureau of Insurance can absorb the costs associated with rulemaking and with the staffing and miscellaneous expenses of the task force.

The costs associated with Legislators' per diem and expenses are expected to be funded within the existing resources of the legislative budget. If the Legislative Council does not approve these expenses, the Legislators serving on the task force will not receive compensation and reimbursement of expenses.

STATEMENT OF FACT

The bill, as amended, provides continuity of health benefits coverage for people who may otherwise be

denied coverage or excluded from coverage for certain health conditions when their group plan changes insurers, or when they as individuals change coverage, for example, when they change jobs and seek coverage under a new employer's group plan. Currently, in these situations, the new contract or policy frequently permits "medical underwriting"; it permits the issuer of the contract or policy to deny coverage to persons otherwise eligible to join the plan because they have a medical condition or have characteristics that make them more likely to develop a medical condition. Alternatively, the issuer may agree to cover the person, but exclude coverage of a preexisting condition, a condition that the person has when applying for coverage, even though the person had coverage for that condition under the prior plan. The amendment protects individuals against breaks in coverage in these situations as follows.

In the first situation, when an employer or other holder of a group contract or policy changes to a different contract or policy issued by any insurer, nonprofit service organization or health maintenance organization, the replacement contract or policy may not deny coverage or exclude coverage of preexisting conditions to any person who was covered under the replaced contract or policy. A short exclusion period may be applied, however, to any person who was not covered for at least 90 continuous days under the replaced contract or policy.

In the 2nd situation, the amendment provides continuity of coverage for persons who move from coverage under a group or individual contract or governmental program into coverage by a group contract, by requiring

the insurer, nonprofit hospital or medical service organization or health maintenance organization that issues the succeeding contract or policy to waive preexisting condition exclusions and medical underwriting to the extent the benefit would have been covered by the prior contract or policy. The amendment limits to 10% the premium increase that may be imposed on a group of fewer than 100 insured employees as a result of claims for preexisting conditions of those persons during their first year of employment. The insurer, nonprofit hospital or medical service organization or health maintenance organization may spread any additional cost among other similar groups it covers.

The amendment also provides an extension of coverage in a 3rd situation. If a person is totally disabled on the date a group contract or policy is discontinued, the contract or policy must extend benefits for a reasonable period under the contract or policy for that person, regardless of subsequent coverage. No premium may be charged for the extension.

The continuity requirements do not generally apply to persons obtaining coverage under individual contracts or policies. With respect to individual contracts or policies, the amendment limits the preexisting condition exclusion period that may be imposed to 6 months, unless the condition requires ongoing medical observation and treatment in which case the benefits for that condition may be excluded for up to 24 months.

Finally, the amendment creates a task force to study additional health insurance continuity issues.

Reported by the Committee on Banking and Insurance
Reproduced and distributed under the direction of the
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(Filing No. S-675)

STATE OF MAINE
SENATE
114TH LEGISLATURE
SECOND REGULAR SESSION

SENATE AMENDMENT "B" to COMMITTEE AMENDMENT "A" to H.P. 1641, L.D. 2274, Bill, "An Act to Ensure Continuity of Health Insurance Coverage"

Amend the amendment by striking out all of section 10 and inserting in its place the following:

'**Sec. 10. Application.** The Maine Revised Statutes, Title 24, section 2349 and Title 24-A, section 2849-B, apply to all policies, contracts and certificates executed, delivered, issued for delivery, or renewed in this State on or after April 1, 1991, and to all policies, contracts and certificates in force on April 1, 1991. All policies, contracts and certificates in force on April 1, 1991, must provide coverage effective April 1, 1991, to individuals who were previously denied coverage, but who would have received coverage had Title 24, section 2349 and Title 24-A, section 2849-B been in effect on the date the individuals become eligible to enroll in the plan. Title 24, section 2350 and Title 24-A, section 2850 apply to all policies and contracts executed, delivered, issued for delivery, or renewed in this State on or after December 1, 1990. All other provisions of this Act apply to all policies, contracts and certificates executed, delivered, issued for delivery, or renewed in this State on or after October 1,

1990. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.'

Further amend the amendment in section 11 by striking out all of subsection 5 (page 13, lines 39 to 41 in amendment) and inserting in its place the following:

'5. The task force shall submit any recommendations for legislation to the First Regular Session of the 115th Legislature and to the Office of the Executive Director of the Legislative Council by December 1, 1990.'

STATEMENT OF FACT

This amendment provides:

1. That the provisions of the committee amendment dealing with continuity of coverage for individuals who change groups will not take effect until April 1, 1991, but will then apply to all contracts in force at that time and to any individuals previously denied coverage, but who would have received coverage if the committee amendment had been in effect when the individuals became eligible to enroll in the plan;

2. That the provisions of the committee amendment limiting exclusions and waiting periods for individual policies will not take effect until December 1, 1990; and

3. That the health insurance continuity task force provided for in the committee amendment will report any

recommendations for legislation to the Legislature by December 1, 1990.

(Senator THERIAULT)
SPONSORED BY: /s/ Illegible

COUNTY: Aroostook

Reproduced and Distributed Pursuant to Senate Rule 12. (4/6/90) (Filing No. S-675)